

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01436

01419

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY in 1b Hrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital			d. STREET ADDRESS 25 Bunch St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Walter WILLIAM ADAMS			4. DATE OF DEATH Month Day Year February 2 1962		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24-1909	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Charles E. Adams			14. MOTHER'S MAIDEN NAME Henrietta - Hebron		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-0801		17. INFORMANT Charles G. Adams - 16 Carver St. Anna, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 acute Pulmonary Edema DUE TO (b) Myocardial infarction ? x DUE TO (c) Arteriosclerotic CVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 3 hr 3 hr. 5 yr.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (as physician) attended the deceased from....., 19....., to.....Feb. 2,....., 1962, that (I) (as) last saw the deceased alive on.....Feb. 2,.....1962, and that death occurred at.....M, from the causes and on the date stated above.					
22a. SIGNATURE Frank M. Shipley			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 12:30 PM		22b. DATE SIGNED 2-2-62
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley			22d. ADDRESS 121 Cathedral St., Annapolis, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 5-62		23c. NAME OF CEMETERY OR CREMATORY St. Marys	
23d. LOCATION (City, town or county) Annapolis, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE C.E.Hicks III			ADDRESS Annapolis, Maryland		
25a. REC'D BY REGISTRAR DATE FEB 13 '62			25b. REGISTRAR'S SIGNATURE Orlando S. Farris		

01110

01110



C. L. Hicks III, Annapolis, Maryland

Feb. 5-52 St. Marys

Annapolis, Md.

Frank J. Miller

1952

Feb. 5-52

James G. Adams - in Charge of Ann. Md.

Leontine - Boston

Marjorie

Feb. 24-1952

Leontine

John Leontine Leontine

1952

Leontine

1952

1952

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01420

01437

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b <b>Few minutes</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A.A.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Glen Burnie</b> d. STREET ADDRESS <b>Route 2 Box 847</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emmett Swindel Armstrong</b>		4. DATE OF DEATH Month <b>February</b> Day <b>7th</b> Year <b>19 62</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/13/00</b>
9. AGE (In years lost birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Molds Maker in a Glass Factory</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Mrs Jennie Lee (daughter)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mitral Insufficiency</b> <b>410X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>September 1961</b> to <b>February 1962</b> that (I) (we) last saw the deceased alive on <b>2/6/62</b> 19 <b>62</b> , and that death occurred <b>8:50A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Gustave H. Faubert M.D.</b>		22b. DATE SIGNED <b>2/7/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		22d. ADDRESS <b>Glen Burnie, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/10/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Elkridge, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, INC. 715 Light St. -30</b>		25a. REC'D BY REGISTRAR <b>FEB 9 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

011310

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01435

01421

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. LENGTH OF STAY IN b. <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ANNE ARUNDEL GENERAL HOSPITAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS - BAY RIDGE</u> d. STREET ADDRESS <u>14 E. LAKE DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>TAMARA SUE BALL</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>FEB. 17 1962</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>DEC. 19-1958</u>	<b>9. AGE</b> (In years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NONE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NONE</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>ANNAPOLIS MD</u>
<b>13. FATHER'S NAME</b> <u>GEORGE L. BALL</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>MILDRED ANN BRANHAM</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>NO</u>		<b>17. INFORMANT</b> <u>GEORGE L. BALL</u> <u>14 E LAKE DRIVE</u> <u>ANNAPOLIS MD</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Streptococcal Meningitis &amp; Septicemia</u> 053.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town) (County) (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/16/62</u> , <b>19</b> <u>1962</u> , <b>to</b> <u>2/17</u> , <b>19</b> <u>1962</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>2/17</u> , <b>19</b> <u>1962</u> , <b>and that death occurred at</b> <u>12 M.</u> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Philip Briscoe</u> M.D.		<b>22b. DATE SIGNED</b> <u>FEB 17, 1962</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>PHILIP BRISCOE</u>		<b>22d. ADDRESS</b> <u>95 CATHEDRAL ST. ANNAPOLIS MD</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>2-20-1962</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hillcrest Memorial</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Annapolis Md</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. Teyler Sons</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 20 '62</u>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Thomas</u>

18110

18110

(M)

(1)

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "George" and "George" are faintly visible.]*

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01439						01422					
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE <b>Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1307 N. Central Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>14 days</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1307 N. Central Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>											
3. NAME OF DECEASED (Type or print) <b>Ella</b>			First <b>W.</b>			Middle <b>Bazemore</b>			Last <b>2</b>		
4. DATE OF DEATH <b>2</b>			Month <b>13</b>			Day <b>19</b>			Year <b>62</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 11, 1885</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Florida</b>			
13. FATHER'S NAME <b>Whitt Watson</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b> <b>522 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Senility due to Chronic Brain Syndrome</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dehydration, Inanition and Uremia</b>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b>		20g. (County) <b>-----</b>		20h. (State) <b>-----</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1/29</b> , 19 <b>62</b> , to <b>2/13</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> , 19 <b>62</b> , and that death occurred at <b>6:30 P.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Lionel McHenry Mapp, M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>2/14/62</b>		
22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>						22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/27/62</b>				23b. DATE THEREOF <b>2/27/62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mount Calvary</b>			
23d. LOCATION (City, town or county) <b>Mount Calvary</b>				23e. (State) <b>Maryland</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>A. Halstead</b>				ADDRESS <b>918 Druid Hill Ave</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

01135

01135



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

Reg. Dist. 01423

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>		c. LENGTH OF STAY IN 1b <b>10 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KIRKBRUGH ARMY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRED</b> Middle <b>BIRD</b> Last <b>BIRD</b>		4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Feb 1878</b>
9. AGE (In years last birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Son, Lt Col Edward Bird (Retired) Same as item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio vascular accident</b> 4-2-2-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3 Feb</b> , 19 <b>62</b> , to <b>12 Feb</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>12 Feb</b> , 19 <b>62</b> , and that death occurred at <b>3:15 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>12 Feb 62</b>			
ACTUAL SIGNATURE <i>Rafael A. Perez-Mera</i> M.D.		12 Feb 62	
PHYSICIAN'S NAME (Type) <b>RAFAEL A. PEREZ-MERA, Capt., M.C. KAH Ft Geo G. Meade, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-14-1962</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert P. Ware</i> Singleton Funeral Home		24a. REC'D BY REGISTRAR DATE <b>FEB 15 '62</b>	
ADDRESS <b>Glen Burnie, Md.</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	

01110

STATE OF TEXAS

01110



*[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a formal document, possibly a certificate or a legal record, with several lines of text and a signature area.]*

*[Signature]*

*[Faint text at the bottom of the page, possibly a footer or date.]*

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01424									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Same b. COUNTY Same				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN lb 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Same				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 134 Salley Rd.					d. STREET ADDRESS Same			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Grace Dorworth Bowdoin					4. DATE OF DEATH February 13th. 19 62				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/8/77		9. AGE (In years last birthday) 84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? u USA		
13. FATHER'S NAME Lewis O. Mosher					14. MOTHER'S MAIDEN NAME Bertha Shoemaker				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Laurence Bowdoin (son)			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH ?									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Gustave H. Faubert, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED 2/14/62				
					Address (Street, city, town, or county) Glen Burnie, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 16, 1962		22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR Wm. Cook, Inc. 1217 St. Paul St.					24a. REC'D BY REGISTRAR DATE FEB 19 '62		24b. REGISTRAR'S SIGNATURE Charles E. Hanes		

15110

01441



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please examine the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01425

01442

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b> c. LENGTH OF STAY IN 1b <b>16 Y.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cypress Creek Road</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b> d. STREET ADDRESS <b>Same</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Paul I. Bowen</b>				4. DATE OF DEATH Month <b>February</b> Day <b>9th.</b> Year <b>19 62</b>			
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/25/04</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Cavanaugh, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Automobile Dealer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>AUTOMOBILE</b>			
13. FATHER'S NAME <b>George W. Bowen</b>				14. MOTHER'S MAIDEN NAME <b>Mellie Crum</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>No</b>			
17. INFORMANT <b>Mrs. Dorothy Hilda Bowen (wife)</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>420-1</b> (c) <b>420-1</b> (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420-1</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <b>2-13-62</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>				22d. LOCATION (City, town, or country) (State) <b>Glen Burnie, Md.</b>			
23. FUNERAL DIRECTOR <b>Robert S. Baranec</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 13 '62</b>			
ADDRESS <b>Severna Park, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01443 CERTIFICATE OF DEATH 01426

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>1 mo. 2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> <u>20X-2</u> d. STREET ADDRESS <u>?</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Maggie</u> Middle <u>Branch</u> Last <u>Branch</u>				<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>19</u> Year <u>1962</u>											
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>March 10, 1883</u>		<b>9. AGE</b> (In years last birthday) <u>78</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-----</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Virginia</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Nelson Branch</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Unknown</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>		<b>17. INFORMANT</b> <u>Hospital Records</u> Address <u>  </u>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>443X</u> <b>Hypertensive Cardiovascular Disease</b> IMMEDIATE CAUSE (a) <u>  </u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u> DUE TO <u>  </u> (b) <u>  </u> (c) <u>  </u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>  </u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Chronic Brain Syndrome Associated with Arteriosclerosis</u>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> <u>Not while</u> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> <u>  </u>		<b>(County)</b> <u>  </u>		<b>(State)</b> <u>  </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1/17</u> <b>to</b> <u>2/19</u> <b>1962, that (I) (we) last saw the deceased alive on</b> <u>2/19</u> <b>1962, and that death occurred at</b> <u>8:45 PM</u> <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>L. Benedict, M. D.</u>						<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2/20/62</u>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>L. Benedict, M. D.</u>						<b>22d. ADDRESS</b> <u>Crownsville State Hospital, Maryland</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u>				<b>23b. DATE THEREOF</b> <u>3-1-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Univ. of Md. Balt.</u>				<b>23d. LOCATION</b> (City, town or county) <u>Md.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. Feea II</u>						<b>ADDRESS</b> <u>Annapolis, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>					

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01458

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 01444 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01427

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sunset Hill</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>2797 Yarnall Road</b>			
3. NAME OF DECEASED (Type or print) First <b>HAROLD</b> Middle <b>D.</b> Last <b>BRITTON</b>				4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-28-1912</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months <b>03</b> Days <b>X</b>		IF UNDER 24 HRS. Hours <b>2</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rating Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Electric Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William A. Britton</b>				14. MOTHER'S MAIDEN NAME <b>Bessie M. Whennen</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Mrs. Dorothy M. Pike-2797 Yarnall Road-Sunset Hill</b>			
17. INFORMANT <b>Mrs. Dorothy M. Pike-2797 Yarnall Road-Sunset Hill</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide Intoxication.</b> <b>9773.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Ran hose from exhaust pipe into auto.</b>			
20c. TIME OF INJURY Hour a.m. <b>2/14</b> p.m. <b>19 62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Lodge</b>		20f. (City or town) <b>St. Margaret</b> (County) <b>A.A.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED <b>2/15/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-19-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or country) <b>Baltimore, Md.</b> (State)	
23. FUNERAL DIRECTOR <b>Wm J. Robertson</b> ADDRESS <b>Balto. Md.</b>				24a. REC'D BY REGISTRAR <b>FEB 16 '62</b> 24b. REGISTRAR'S SIGNATURE <b>Wm J. Robertson</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
01445 CERTIFICATE OF DEATH 01429																			
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. LENGTH OF STAY IN 1b <u>32 hours</u>														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Churchton</u>														
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					d. STREET ADDRESS <u>1</u>														
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Earl</u> Last <u>BROWN</u>					4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1962</u>														
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 12, 1962</u>		9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>8</u> Min. <u>50</u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>									
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					13. FATHER'S NAME <u>Richard Earl JOHN</u>					14. MOTHER'S MAIDEN NAME <u>Barbara Lola BROWN</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>					16. SOCIAL SECURITY NO. <u>—</u>					17. INFORMANT <u>Hospital records</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - 26 weeks gestation.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Retroplacental hemorrhage.</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH <u>—</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>—</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>—</u> 19 <u>—</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>					20f. (City or town) (County) (State) <u>—</u>									
21. I certify that (I) (the deceased) attended the deceased from <u>Feb. 12, 1962</u> , to <u>Feb. 13, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb. 12, 1962</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.										22a. SIGNATURE <u>Lionel McH. MAPP</u>					22b. DATE SIGNED <u>2/13/62</u>				
22c. PHYSICIAN'S NAME (Type) <u>Lionel McH. MAPP, M.D.</u>					22d. ADDRESS <u>20 Dean St., Annapolis, Md.</u>					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>					23b. DATE THEREOF <u>Feb 14, 1962</u>					23c. NAME OF CEMETERY OR CREMATORY <u>Holland Cemetery</u>									
23d. LOCATION (City, town or county) (State) <u>Churchton</u>					24. FUNERAL DIRECTOR'S SIGNATURE <u>T A Hardesty + Son</u>					25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>									
25b. REGISTRAR'S SIGNATURE <u>—</u>					25c. DATE <u>FEB 19 1962</u>					25d. ADDRESS <u>Galesville Md</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01446  
01431  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>610 Second St. (Eastport)</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>BUTLER</u> Last <u>BUTLER</u>		4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16, 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Elizabeth Butth</u>		14. MOTHER'S MAIDEN NAME <u>Henry Butth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Simath Butth, Annapolis, Md</u>	
17. INFORMANT <u>Simath Butth, Annapolis, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 420.0 DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>A.P.H.D. with long years Fibrosis</u> (c) <u>3 weeks</u>		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(husband)</u> attended the deceased from <u>Feb. 4, 1962</u> , to <u>Feb. 4, 1962</u> that (I) <u>(not)</u> last saw the deceased alive on <u>Feb. 4, 1962</u> , and that death occurred at <u>3:45 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Helen Y. O'Herlity</u> M.D.		22b. DATE SIGNED <u>2/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. T. O'HERLITY MD</u>		22d. ADDRESS <u>5 Central Ave., Glen Burnie, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-8-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Annapolis Neck</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Johnson</u>		25a. REC'D BY REGISTRAR <u>Feb 9 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

10111

OFFICE OF THE SECRETARY OF THE ARMY

10111



TO THE SECRETARY OF THE ARMY  
FROM THE SECRETARY OF THE ARMY  
SUBJECT: [Illegible]  
[Illegible text follows]

[Illegible text follows]

[Illegible text follows]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 of this certificate should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01447

CERTIFICATE OF DEATH

01432

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>		c. LENGTH OF STAY IN 1b <b>5 hrs 25 min Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KIMBROUGH ARMY HOSPITAL</b>		d. STREET ADDRESS <b>5216 Cromarty Road</b>	
3. NAME OF DECEASED (Type or print) First <b>GARY</b> Middle <b>MICHAEL</b> Last <b>CALDWELL</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>9</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 Feb 62</b>
9. AGE (In years last birthday) <b>5</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>25</b>	IF UNDER 24 HRS. Hours <b>5</b> Min <b>25</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert X Caldwell</b>		14. MOTHER'S MAIDEN NAME <b>Nora Isabel Evers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Father</b>		Address <b>Same as item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unknown</b> <b>776X</b> DUE TO <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-</b> DUE TO <b>-</b> (c) <b>-</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs 25 min</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9 Feb 1962</b>		20f. (City or town) (County) (State) <b>9 Feb 1962</b>	
21. I certify that (I) <b>Stuart Bernstein</b> attended the deceased from <b>9 Feb 1962</b> to <b>9 Feb 1962</b> , that (I) <b>yes</b> saw the deceased alive on <b>9 Feb 1962</b> , and that death occurred at <b>8:00 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Stuart Bernstein</b>		22b. DATE SIGNED <b>9 Feb 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>STUART BERNSTEIN, Capt., M.C.</b>		22d. ADDRESS <b>Kimrough Army Hosp Ft Geo G. Meade, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/12/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore-6 Md</b>	
24a. FUNERAL DIRECTOR'S SIGNATURE <b>Sam B. Williams</b>		24b. ADDRESS <b>4306-Bridge Rd, Baltimore-6, Md</b>	
25a. REC'D BY REGISTRAR <b>DATE FEB 14 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

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CENTRAL BANK OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## 1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01448

CERTIFICATE OF DEATH

01433

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> f. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b> d. STREET ADDRESS <b>59 Shaw Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rachel</b> First Middle Last <b>Calvert</b>		4. DATE OF DEATH Month Day Year <b>February 2 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/19/87</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Miller</b>		14. MOTHER'S MAIDEN NAME <b>Ellen M. Neal</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>57-1-62</b>	
17. INFORMANT <b>William Reese</b>		Address <b>57 Shaw St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>451X Dementia Arteriosclerotic</b> DUE TO <b>myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>myocardial infarction</b> DUE TO (c) <b>myocardial infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-1-62</b> to <b>2-2-62</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2-1-62</b> , 19 <b>62</b> , and that death occurred at <b>7:30</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Ar T. Allen</b> M.D.		22b. DATE SIGNED <b>2-3-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Aris T. Allen</b>		22d. ADDRESS <b>Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-6-1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hall</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 9 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

01133

CERTIFICATE OF DEATH

01133



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01449						01434					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
ANNE ARUNDEL			MARYLAND			Md.			D.C.		
c. LENGTH OF STAY IN			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
30 yrs.			HOMewood CONValescent			X Arnold			1 Rt 1 Box 76		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
Ralph M. Carey						Feb 13 1962					
5. SEX		6. COLOR OR RACE		7. MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Nov 13, 1880		87 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Pipe Fitter				Oil Business				Rhode Island			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Unknown						Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
No				220 011183				Mrs. Mary Carey - Above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						3 wks.					
4200 DUE TO						Myocardial Insufficiency					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b) Atherosclerotic Heart Disease					
DUE TO (c)						3 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
Senility											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year						20d. INJURY OCCURRED					
Hour a.m. p.m. 19						While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1-5-58, to 2-13-62, that (I) (we) last saw the deceased alive on 2-10-1962, and that death occurred at 1 A.M. from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
James R. Martin						2-13-62					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
JAMES R. MARTIN						6 SHAW ST. ANNAPOLIS, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)	
Burial				2-15-62		Lorraine Park				Woodlawn Md	
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR					
Robert A. Baranco, Sealine Pk.						DATE FEB 16 '62					
						25b. REGISTRAR'S SIGNATURE					
						Arthur S. Hanna					

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01450 CERTIFICATE OF DEATH 01435											
1. PLACE OF DEATH a. COUNTY <u>AA</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCHTON MD</u>				c. LENGTH OF STAY IN tb <u>18 months</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XCHURCHTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1</u>						d. STREET ADDRESS <u>1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>MARSHALL</u> Last <u>CLARK</u>						4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1962</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>6/26/98</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School teacher</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Alfred H Marshall</u>						14. MOTHER'S MAIDEN NAME <u>Lizzie Barnham</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>029 037980</u>		17. INFORMANT Address <u>Mrs Marie Scott Churchton MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>D.O.A.</u> <u>3 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Rheumatoid Arthritis</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <u>  </u>							
20c. TIME OF INJURY Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>1-9-57</u> 19 <u>  </u> , to <u>2-26</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>2-23-62</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank M. Shipley</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-27-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>Frank M. SHIPLEY, M.D.</u>						22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/25/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		23d. LOCATION (City, town or county) (State) <u>Walesville MD</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>						ADDRESS <u>Walesville Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>1 2 Acton Place</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>Albert</u> Last <u>CLARK</u>				<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>13</u> Year <u>19 62</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 12, 1890</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pharmacist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>George W. Clark</u>				14. MOTHER'S MAIDEN NAME <u>Anna R. Lowman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Helen K. Clark</u> Address <u>(2)</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V.A.</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>the husband</u> attended the deceased from <u>2-12-62</u> , 19 <u>62</u> , to <u>2-13-62</u> , 19 <u>62</u> , that (I) <u>(x)</u> last saw the deceased alive on <u>2-13-62</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank M Shipley</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-13-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK M SHIPLEY</u>				22d. ADDRESS <u>Annapolis Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-15-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cent</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Vayler Sues</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 16 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01452

CERTIFICATE OF DEATH

01437

Items 11 & 12 Film 0308 3/9/62 mh

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Hattie W. Colbert Phelps Colbert</b>		4. DATE OF DEATH Month Day Year <b>February 24, 19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-16-1875</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11c. BIRTHPLACE (State or foreign country) <b>Anne Arundel, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown / USA</b>	
13. FATHER'S NAME <b>William Phelps</b>		14. MOTHER'S MAIDEN NAME <b>Sarah ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Walter Colbert</b>		Address <b>53 Fleet St. Annapolis, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>? yrs.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>11-8-1961</b> , 19____, to <b>2-24-1962</b> , 19____, that (I) ( <del>we</del> ) last saw the deceased alive on <b>2-17</b> , 19 <b>62</b> , and that death occurred at <b>7A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>James M. Pair</b>		22b. DATE SIGNED <b>2-24-1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>James M. Pair, Md.D.</b>		22d. ADDRESS <b>400 N. Carrollton Ave. Balto. 23, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-27-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		23d. LOCATION (City, town, or county) (State) <b>ANNAPODIS - MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hicker III</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 2 '62</b>	
ADDRESS <b>Annapolis Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Hicker</b>	

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CERTIFICATE OF DEATH

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Philip Colport

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01438											
1. PLACE OF DEATH a. COUNTY <b>AA Co</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>AA Co</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERSTONE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X CUMBERSTONE MD</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS <b>1</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ALVIN</b>				First Middle Last <b>OWEN CULLEMBER SR.</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>9</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>May 23, 1894</b>		9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Lothian MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES WILLIAM CULLEMBER</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET WARD</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)				16. SOCIAL SECURITY NO. <b>213-22-1842</b>				17. INFORMANT Address <b>Alvin Owen Cullember Sr. Cumberstone MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ac. Coronary Thrombosis</b> <b>420.1</b> DUE TO <b>Arteriosclerotic C.V. disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Instants yrs.</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Thrombosis</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Early 8, 1960</b> to <b>Feb 9, 1962</b> that (I) (we) last saw the deceased alive on <b>1/26/62</b> and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Mannie Klawans</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>MARICE F. KLAWANS, MD</b>				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
<b>Burial</b>		<b>Feb 12 1962</b>		<b>MT Zion Cemetery</b>				<b>Lothian MD</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>TA Hardesty + Son</b>				ADDRESS <b>Galesville MD</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 19 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Past may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01454  
01439

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY in 1b <b>Maryland</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel Gen'l. Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>X Pasadena (Magoth Beach)</b> d. STREET ADDRESS <b>Riverside Drive Apt. #5</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Muriel H. Emmons</b>		4. DATE OF DEATH Month Day Year <b>FEB 23 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6 June 1906</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Whitehall, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eugene Ford</b>		14. MOTHER'S MAIDEN NAME <b>Ada McJilton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMATION <b>Mr. Russell Emmons - Same as 2</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL BRONCHO-PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>BRONCHOGENIC CARCINOMA</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. INTERVAL BETWEEN ONSET AND DEATH <b>48 HRS.</b> <b>1 YEAR</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>FEB 2</b> , 1962 to <b>FEB 22</b> , 1962, that (I) ( <del>we</del> ) last saw the deceased alive on <b>FEB 22</b> , 1962, and that death occurred at <b>6:57 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Arthur Lankford Jr.</b> M.D.		22b. DATE SIGNED <b>2/23/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR LANKFORD JR.</b>		22d. ADDRESS <b>2934 MOUNTAIN RD PASADENA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>27 Feb. 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Glen Burnie - Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. V. Singleton</b>		25a. REC'D BY REGISTRAR <b>28 FEB 62</b>	
ADDRESS <b>Glen Burnie, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Thomas</b>	

01138

01134

(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01455

01440

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL - Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>Rt-4, Box-203 (Cape St. Claire)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Jessie</u> Middle <u>ERDMAN</u> Last <u></u>				<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>4</u> Year <u>19 62</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 31, 1883</u>	
9. AGE (in years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent (ret.) Institution</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John W. Hayne</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Craig</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u> <u>//////////</u>				16. SOCIAL SECURITY NO. <u>219 30 8000</u>		17. INFORMANT <u>Mrs. Jessie Diggs</u> Address <u>Same As #2</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral artery thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertensive Pneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Jan. 23, 1962</u> , to <u>Feb. 4, 1962</u> , that (I) <u>xxx</u> last saw the deceased alive on <u>Feb. 4, 1962</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard N. Peeler</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard N. Peeler, M.D.</u>				22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6th Feb. '62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard N. Peeler</u>				ADDRESS <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 8 '62</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

01441

01456

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PURAH, ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Annapolis Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>EWING</u> Last <u>1</u>		4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1885</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE EHATT</u>		14. MOTHER'S MAIDEN NAME <u>MARIA ANSTATT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT Address <u>MRS. WALTER R. HARTKE #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 yr.</u> (c) <u>1 yr.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 3, 1962</u> to <u>Feb 2, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 30, 1962</u> and that death occurred at <u>5 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James R. Martin</u>		22b. DATE SIGNED <u>Feb 2, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		22d. ADDRESS <u>6 SHAW ST. ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-3-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		23d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Seymour</u>		25a. REC'D BY REGISTRAR <u>Feb 5 '62</u>	
ADDRESS <u>Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

01141

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01457

## CERTIFICATE OF DEATH

01442

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Arnold, Annapolis</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Arnold</u>	
c. LENGTH OF STAY in 1b <u>45 DAYS</u>		d. STREET ADDRESS <u>Arnold P.O.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>A.A. GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>VERNON</u> Last <u>Fay</u>		<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>6</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jan 11, 1885</u>
<b>9. AGE</b> (In years last birthday) <u>77</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Painter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>retired</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>CHICAGO, ILLINOIS</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>JOHN V. FAY</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>IDA OCEA BYRON</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>212-14-2605</u>	
<b>17. INFORMANT</b> <u>MRS. OCEA DENLEIN</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Arterio cardiovascular Disease</u> DUE TO (b) <u>Arterio cardiovascular Disease</u> (c) <u>Years</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u>11 PM</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov</u> , 19 <u>61</u> , to <u>Feb 6</u> , 19 <u>62</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 26</u> , 19 <u>62</u> <b>and that death occurred at</b> <u>11 PM</u> , <b>from the causes and on the date stated above.</b>		<b>22a. SIGNATURE</b> <u>Faye W Allen</u> M.D. <b>22b. DATE SIGNED</b> <u>Feb 6, 1962</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Faye W. Allen</u>		<b>22d. ADDRESS</b> <u>62 Cathedral St Annapolis, Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>2/9/62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>OAK LAWN</u>		<b>23d. LOCATION</b> (City, town or county) <u>BALTO. CO.</u> (State) <u>MD.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>George W. Hoffmann</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 9 '62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

01101

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John V. Fry  
214-10000 Mrs. Greenberg  
Chicago, Illinois

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01458

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01443

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>1 Monticello Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>ADDISON</b> Middle <b>J</b> Last <b>FINK</b>				4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 27, 1916</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months <b>45</b> Days <b>45</b>		IF UNDER 24 HRS. Hours <b>45</b> Min. <b>45</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Cutter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retail store</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Frank J. Fink</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Tucker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO. <b>220 09 6527</b>			
17. INFORMANT <b>Mr Thomas J. Fink - Son - Same ad # 2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) <b>partial</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Pulmonary Emphysema</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>partial</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Howard G. Shaub</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>HOWARD G. SHAUB, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED <b>2/27/62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 2, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR <b>Hopping Funeral Home</b>				24a. REC'D BY REGISTRAR <b>2 '62</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hanes</b>							

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THE NATIONAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
JAN 11 1964  
MEMORANDUM  
TO : DIRECTOR  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
[Illegible text follows, including a date stamp 'JAN 11 1964' and a signature block.]

VR A15 (4)  
15M 7/67

01110

01110



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01460					01445						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)						
a. COUNTY		Anne Arundel			a. STATE		b. COUNTY				
		MARYLAND			md		Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
Annapolis					X Severna Park						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Anne Arundel General Hospital											
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
							Gardner		February 3 1962		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		February 3, 1962		yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
						Annapolis, Maryland			USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Robert Gardner					Barbara						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT			Address	
							Hospital records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)										(5 months) w/ 15-02	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from Feb. 3, 1962, to Feb. 3, 1962; that (I) (we) last saw the deceased alive on 2-3-1962, and that death occurred at 5:45 A.M. from the causes and on the date stated above.											
22a. SIGNATURE					22b. DATE SIGNED						
Francis I. Codd M.D.					Feb 3, 1962						
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
Dr. Francis I. Codd					Severna Park, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
Feb 5, 1962			Feb 5, 1962		Cedar Hill			Baltimore md			
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Geo L. Schorsch					2101 Frederick Ave		DATE FEB 6 '62		Arthur S. Kraus		
2063161024											

01112

01112

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Amn. total annual cost

February 1, 1901

Amn. total annual cost

February 1, 1901

Amn. total annual cost

February 1, 1901

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Amn. total annual cost

February 1, 1901

Amn. total annual cost

February 1, 1901

Amn. total annual cost

February 1, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01446

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First <u>Harner</u> Middle <u></u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-1882</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Agnes Mack, Harwood Md.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/17</u> 19 <u>61</u> , to <u>2/3</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/31</u> 19 <u>62</u> , and that death occurred at <u></u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>S. Borssuck</u> M.D.		22b. DATE SIGNED <u>2/5/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. Borssuck</u>		22d. ADDRESS <u>Annapolis, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-7-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #1</u> ADDRESS <u>Annapolis Md</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 9 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

04416

CERTIFICATE OF DEATH

1911

(M)

CHIEF TOWN

2020

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH					01447				
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY in 1b <u>WRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Solley Road</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>Solley Road - Rt. 11 - Box 120</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>THOMAS G. GOETZ</u>					4. DATE OF DEATH Month <u>February</u> Day <u>23</u> Year <u>1962</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>28th Sept. 1878</u>		9. AGE (In years last birthday) <u>83</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self-emp.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Green Castle, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>(unknown) Goetz</u>					14. MOTHER'S MAIDEN NAME <u>(unknown)</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Evelyn Shawen</u> Address <u>Pasadena, Md. Powhatan Beach Rd.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> 420.0 DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>none</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>Jan 2</u> , 19 <u>62</u> to <u>February 23</u> , 19 <u>62</u> ; that (I) ( <u>we</u> ) last saw the deceased alive on <u>Feb. 21</u> , 19 <u>62</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>R. M. McLaughlin</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/23/62</u>		
22c. PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>					22d. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>26th Feb. '62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Brooklyn, RFD, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. M. McLaughlin</u> ADDRESS <u>Glen Burnie, Md.</u>					25a. REC'D BY REGISTRAR <u>FEB 28 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>		

01417

01482

M

Page number

Via

Address

Address

Post Office

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> c. LENGTH OF STAY IN b. <b>89 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bayside Beach Drive</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b> d. STREET ADDRESS <b>Bayside Beach Drive</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Harry Hancock</b> First Middle Last <b>4. DATE OF DEATH</b> <b>Feb 14 19 62</b> Month Day Year		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Sept. 8, 1872</b> <b>9. AGE</b> (In years last birthday) <b>89 yrs.</b> <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farmer</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Farm</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>AA Co., Md.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>Harry Hancock</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Matilda Wilkinson</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>-----</b> <b>16. SOCIAL SECURITY NO.</b> <b>-----</b> <b>17. INFORMANT</b> <b>Miss Matilda Cook, Same as 2</b> Address		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>5 years.</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify</b> that (I) (this hospital) attended the deceased from <b>Nov. 1, 1949</b> to <b>February 14, 1962</b> that (I) (we) last saw the deceased alive on <b>February 13, 1962</b> , and that death occurred at <b>11 A.M.</b> , from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <b>R.M. McLaughlin</b> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <b>R.M. McLaughlin</b> <b>22d. ADDRESS</b> <b>3708 Mountain Rd. Pasadena, Md.</b> <b>22e. DATE SIGNED</b> <b>2/15/62</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>2/18/62</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Family Plot</b> <b>23d. LOCATION</b> (City, town or county) (State) <b>AA Co., Pasadena, Md.</b>	
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <b>Hopping and Kirkley</b> ADDRESS <b>Glen Burnie, Md.</b> <b>25a. REC'D BY REGISTRAR</b> <b>FEB 19 '62</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kneese</b>			

01418

01183

AA

Ms.

Anne Arnold

M

Presidents

89 yrs

Presidents

Bayside Beach Drive

Bayside Beach Drive

Ms

Ms

Presidents

Harry

89

Sept. 8, 1972

x

White

Male

USA

AA Co., MS.

Own Farm

Farmer

Wetlands Williamson

Harry Hancock

Miss Nettie Cook, same as S

no

AA Co., Presidents, MS.

Family Plot

2/18/62

Family

Hopping and Kirtley, Allen Burnett, MS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

VR A15 (4)  
15M 7/61

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01464		01449	
1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE, Md.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>	
c. LENGTH OF STAY IN 1b <u>7 YRS</u>		d. STREET ADDRESS <u>507 DOUGLAS ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CROWNSVILLE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM</u> <u>ERNEST</u> <u>HANDY</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY 10 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 1, 1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>WICOMICO CO., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u># UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>214107307</u>	
17. INFORMANT <u>STATISTICAL DATA FROM PATIENT'S HOSP. CHART</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation.</u> 304 X DUE TO <u>Aspiration of regurgitated food.</u> Conditions, if any, which gave rise to immediate cause (b) <u>Senile Psychosis.</u> (a), stating the underlying cause last. DUE TO (c) <u>Chronic Brain Syndrome due to Cerebral Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/10/62</u> to <u>2/10/62</u> , that (I) (we) last saw the deceased alive on <u>2/10/62</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Lionel McHenry Mapp</u> M.D.		22b. DATE SIGNED <u>2/11/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>2 14 62</u>		23b. DATE THEREOF <u>2 14 62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green acre</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James Wright</u> ADDRESS <u>Princess Ann Md</u>		25a. REC'D BY REGISTRAR <u>FEB 16 62</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Madsen</u>			

01010

DECLARATION OF DEATH

01010

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DECLARATION OF DEATH  
I, the undersigned, being a resident of the State of New York, do hereby certify that  
the within and foregoing is a true and correct copy of the original as the same appears  
from the records of the Department of Health of the State of New York.  
GIVEN UNDER MY HAND AND SEAL OF OFFICE this 1st day of January, 1901.  
J. B. CROFT, Registrar General of the State of New York.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01598  
CERTIFICATE OF DEATH  
02692

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. LENGTH OF STAY IN 1b <u>79 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Severn</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>Harris</u> Middle Last		4. DATE OF DEATH <u>Feb. 5<sup>th</sup></u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1883</u> 79 yrs.
9. AGE (In years, last birthday, yrs. Months Days Hours Min.) <u>79</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prof.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Severn, A.A. Co., Md., U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jooyer</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>John Harris, Severn, Md.</u>	
17. INFORMANT <u>John Harris, Severn, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arterio sclerosis</u> <u>1750.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Seriously</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 yrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>✓</u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan 8<sup>th</sup> 1962</u> to <u>Feb 5<sup>th</sup> 1962</u> that (I) (we) last saw the deceased alive on <u>Feb. 4<sup>th</sup> 1962</u> and that death occurred at <u>9:00</u> M, from the causes and on the date stated above.	
22a. SIGNATURE <u>Frank E. Shipley, M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D., Savage, Md</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/10/62</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Gambrells</u>		23d. LOCATION (City, town or county) (State) <u>Gambrells, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Eldon Wilson</u> ADDRESS <u>1000 Brantly St. Baltimore</u>		25a. REC'D BY REGISTRAR <u>MAR 12 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

08835

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND  
01465  
04150  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Annapolis</b> d. STREET ADDRESS <b>Rt-2, Box-423</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Gus</b> Middle <b>HARRIS</b> Last <b>HARRIS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 17, 1898</b>
9. AGE (In years last birthday) <b>63 yrs.</b>		10. IF UNDER 1 YEAR Months <b>63</b> Days <b>63</b>	11. IF UNDER 24 HRS. Hours <b>63</b> Min. <b>63</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEAM</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>SAMPSON HARRIS</b>		14. MOTHER'S MAIDEN NAME <b>Nancy HARRIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, give year or dates of service)</b>		16. SOCIAL SECURITY NO. <b>214-05-1616</b>	
17. INFORMANT <b>Lillie Harris - Annapolis, Md.</b>		Address <b>Annapolis, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cerebral Haemorrhage</b> (a), stating the underlying cause last. } DUE TO <b>Essential hypertension</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>36 hours</b> <b>Year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>Year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (do not) attended the deceased from <b>Feb. 14, 1962</b> to <b>Feb. 15, 1962</b> , that (I) (do not) saw the deceased alive on <b>Feb. 15, 1962</b> , and that death occurred at <b>5:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>G. Church</b>		22b. DATE SIGNED <b>2/16/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>GERARD CHURCH</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2-18-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Richards Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Easton, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Ashwell, Easton, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 20 1962</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

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WEST COAST OF AFRICA

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Nancy Harris

Farmer  
Sampson Harris

515-5244  
Lester Harris - Sampson, Ind.

General Thompson  
Lester Harris

General Thompson

8-17-62  
Richardson  
General Thompson, Ind.

Richardson

Ind

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Form Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS					
Found in the woods near Skidmore					Annapolis Route 2, Box 376					
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last <b>HIIDA MAE HARRIS</b>					Month Day Year <b>February 23, 1962</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-19-1935</b>		9. AGE (in years last birthday) <b>26</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		IF UNDER 1 YEAR Months Days Hours Min.		
13. FATHER'S NAME <b>Phillip Harris</b>					14. MOTHER'S MARDEN NAME <b>Tanger Cromwell</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give year or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>Etta Cromwell R. 2B04376</b>					
17. INFORMANT Address										
<b>Etta Cromwell R. 2B04376</b>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Epilepsy</b> <b>353.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <b>Howard H. Shaub</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>HOWARD G. SHAUB, M. D.</b>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
					DATE SIGNED <b>2/24/62</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>2-28-1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Broadneck</b>		22d. LOCATION (City, town, or country) (State) <b>St. Margarets M.C.</b>			
23. FUNERAL DIRECTOR <b>Wm. Reese II</b>					108. W. Washington St. <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>1 '62</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. J. J.</b>	

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CERTIFICATE OF DEATH

01467

01452

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		d. STREET ADDRESS <b>500 Crain Highway</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>HEMSTETTER</b> Last <b>HEMSTETTER</b>				4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>1962</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1918</b>	9. AGE (In years last birthday) <b>43 yrs.</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Walter R. Neall</b>				14. MOTHER'S MAIDEN NAME <b>Grace McKinley</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212 - 20 - 7188</b>		17. INFORMANT <b>Edward Hemstetter, same as 2</b>		Address <b></b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 332X DUE TO <b>L. Cerebral thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Generalized arterio sclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus, chronic pyelonephritis, myocardial hypertrophy</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 week</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from <b>Feb. 4, 1962</b> to <b>Feb. 9, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 9, 1962</b> , and that death occurred at <b>2:40 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>G. Church</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb 13 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gerard Church, M.D.</b>				22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/12/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping and Kirkley, Glen Burnie, Md.</b>				25a. REC'D BY REGISTRAR <b>Feb 13 1962</b>		25b. REGISTRAR'S SIGNATURE <b>William L. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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NOTHING TO REPORT, CHANGING...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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WYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
01468  
CERTIFICATE OF DEATH

01453

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. LENGTH OF STAY IN 1b <b>16 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>				d. STREET ADDRESS <b>Rt. 4 Box 90</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>W. Henson</b> Last				4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-10-1880</b>	
9. AGE in years lost (thday) yrs. <b>81</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.		IF UNDER 24 HRS. Months <b>11</b> Days <b>11</b> Hours <b>11</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Not known</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>George Henson</b>				14. MOTHER'S MAIDEN NAME <b>Mary Flewood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Echard, D.P.W. A.A.Co.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic cardiac decompensation</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes</b> <b>? yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic degenerative arthritis. Chronic cystitis.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>10-26-1960</b> to <b>2-21-1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 17, 1962</b> , and that death occurred at <b>8AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>James M. Pair</b>				22b. DATE SIGNED <b>2-22-1962</b>			
22c. PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>				22d. ADDRESS <b>400 N. Carrollton Avenue Balto. 23 Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2-26-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Broadneck</b>	
23d. LOCATION (City, town, or county) (State) <b>St. Margaret, Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. - Anna M.D.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 23 1962</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01469						01454					
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Crownsville State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1010 E. Eager Street</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>Calaphas Hines</b>						4. DATE OF DEATH Month Day Year <b>2 20 19 62</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Sep.</b>		8. DATE OF BIRTH <b>November 20, 1915</b>		9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months Days <b>20 19 62</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rance Hines</b>						14. MOTHER'S MAIDEN NAME <b>Julia</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>160-16-9223</b>		17. INFORMANT <b>Hospital Records</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>353.2</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest due to Status Epilepticus</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/16</b> , 19 <b>62</b> , to <b>2/21</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/21</b> , 19 <b>62</b> , and that death occurred at <b>9:55</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>L. Benedict, M. D.</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>2/21/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>						22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/26/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY Cem.</b>		23d. LOCATION (City, town or county) <b>Brooklyn Md.</b>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>E. O. Wilson</b>						ADDRESS <b>1000 Branch Key Ave.</b>		25a. REC'D BY REGISTRAR <b>FEB 26 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

01151

01151



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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt 1 Bot 114</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> x d. STREET ADDRESS <u>Rt 1 Bot 114</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Henry James</u> First Middle Last 4. DATE OF DEATH <u>2</u> <u>22</u> <u>1962</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Col</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>5-8-1900</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MARDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-42708</u>	
17. INFORMANT <u>Blake Green, Rt 1 Crownsville Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lubren crisis.</u> 00811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>2/12/62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-28-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Waterbury Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese</u> ADDRESS <u>Anna Md</u>		24. REC'D BY REGISTRAR <u>1 '62</u>	
25. REGISTRAR'S SIGNATURE <u>Arthur S. Kinsaid</u>			

01325

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01325



RECEIVED  
JAN 10 1964  
FBI - NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01471  
01436  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY in 1b <b>22 years</b> <b>4 mos 6 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chance</b> d. STREET ADDRESS <b>?</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Dennis</b>		4. DATE OF DEATH Month <b>2/</b> Day <b>11/</b> Year <b>1962</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1874</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration &amp; Inanition</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Anorexia</b> (c) <b>Senility</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old Healed Myocardial Infarct</b> <b>Chronic Brain Syndrome due to Cerebral and Generalized Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH
20c. TIME OF INJURY Hour a.m. <b>-----</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/5</b> to <b>2/11</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/11</b> , 19 <b>62</b> , and that death occurred at <b>11:30p</b> , from the causes and on the date stated above.						
22a. SIGNATURE <b>[Signature]</b> M.D.		22b. DATE <b>2/13/62</b>		22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		
22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>		22e. REC'D BY REGISTRAR <b>Feb 23 '62</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>2/20/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>University of Med. Sch. Balt.</b>		23d. LOCATION (City, town or county) (State) <b>Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Reese II</b>		24a. ADDRESS <b>108 W. Washington St.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01457

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA DO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA CO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian - MD</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Thomas</u> Last <u>Sonies</u>		4. DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-16-1894</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u>17</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>HARWOOD, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Tudor Jones.</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Weir Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>214-40-2850</u>	
17. INFORMANT <u>Mrs Wm. Thomas Jones</u>		Address <u>Lothian, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>---</u> a. m. <u>---</u> p. m. <u>---</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-4-62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB 6, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT ZION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>Lothian MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>T A Hardesty + Son</u>		ADDRESS <u>Galesville, Md</u>	
24a. REC'D BY REGISTRAR <u>FEB 13 '62</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

01452

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MINNESOTA STATE DEPARTMENT OF HEALTH - BUREAU ONE

11-13



Name of Deceased		Sex		Age		Date of Death	
Place of Death		Cause of Death		Manner of Death		Signature of Medical Examiner	
History of Illness		Physical Examination		Mental Examination		Autopsy	
Laboratory Examinations		Toxicology		Microbiology		Histology	
Radiology		Pathology		Immunology		Genetics	
Other		Other		Other		Other	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, place 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01473

CERTIFICATE OF DEATH

01458

Items 11 & 12 Film G308 3/1/62 iwk

1. PLACE OF DEATH a. COUNTY <u>H.A.</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>211 10th Ave</u>		d. STREET ADDRESS <u>211 10th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Anton J.</u> Middle <u>Malivoda</u> Last <u></u>		4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-13-91</u>
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stewardess</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Europe Czech</u>		12. CITIZEN OF WHAT COUNTRY? <u>Czech</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Family - Jane</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apurational pneumonia</u> DUE TO (b) <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Encephalomalacia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET OF DEATH <u>2 yr</u> <u>3 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>December 1959</u> to <u>Feb. 18, 1962</u> , that (I) (we) last saw the deceased alive on <u>Feb. 17, 1962</u> and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>H. G. Summers</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>H. G. Summers</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2-22-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>McLure - 13 E Fort Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 20 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles L. Kinner</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01459

01474

Item 7 Film 3507 2/26/62 i.m.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>DOA</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <del>Anne Arundel</del> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>814 Boucher Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Deale</u> Middle <u>W</u> Last <u>LEATHERBURY</u>		<b>4. DATE OF DEATH</b> Month <u>February</u> Day <u>14</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <u>Single</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>May 5, 1901</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>City Garage, Annapolis</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>
<b>13. FATHER'S NAME</b> <u>Frank O</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Sara J WINDSOR</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WWII</u>		<b>16. SOCIAL SECURITY NO.</b> <u>714079093</u>	
<b>17. INFORMANT</b> <u>Mrs Jessie Hertel Davidsonville Md</u>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12-10-1960</u> <b>to</b> <u>2-6-1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2-6-1962</u> <b>and that death occurred at</b> <u>4:30 PM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>James R. Martin</u> M.D.		<b>22b. DATE SIGNED</b> <u>2-15-62</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>James R. MARTIN, M.D.</u>		<b>22d. ADDRESS</b> <u>6 Shaw St., Annapolis, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>2-16-62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Bethlehem National</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore Md.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Rebecca Hardisty</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>FEB 19 '62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>			

01139

01139



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
CERTIFICATE OF DEATH																							
01475																							
01460																							
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>10 years 4 mos. 26 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b> d. STREET ADDRESS <b>?</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle Last <b>Lee</b>			4. DATE OF DEATH Month <b>2</b> Day <b>15</b> Year <b>19 62</b>																				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 23, 1938</b>		9. AGE (In years last birthday) <b>23</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>15</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>62</b>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>William Lee</b>						14. MOTHER'S MAIDEN NAME <b>Alice Marshall</b>																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>577-26-0786</b>				17. INFORMANT <b>Hospital Records</b>				Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tuberculosis Meningitis</b> DUE TO <b>015X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Tuberculosis Lymphadenitis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Embolism, Terminal</b> INTERVAL BETWEEN ONSET AND DEATH																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>9/14</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>9/14</b> , 19 <b>62</b> to <b>2/15</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>2/15</b> , 19 <b>62</b> and that death occurred at <b>1:30p.</b> M, from the causes and on the date stated above.																							
22a. SIGNATURE <b>Lionel McHenry Mapp</b>						22b. DATE SIGNED <b>2/15/62</b>																	
22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>						22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Feb. 19/62</b>				23b. DATE THEREOF <b>Feb. 19/62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas</b>				23d. LOCATION (City, town or county) (State) <b>Aguasco Md</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>George A. Kelson Aguasco, Md</b>						25a. REC'D BY REGISTRAR <b>Arthur S. France</b>						25b. REGISTRAR'S SIGNATURE <b>Arthur S. France</b>											
DATE <b>FEB 21 '62</b>																							

01110

01110

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01476

## CERTIFICATE OF DEATH

02704

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riva</b> d. STREET ADDRESS <b>Dandsonville</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Bobby</b> First Middle Last <b>LOWE</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>2 24 19 62</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>2-22-62</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>
<b>13. FATHER'S NAME</b> <b>William H. Lowe</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Helen Blake</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT</b> <b>William Files Lowe Dandsonville</b> Address
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory distress syndrome</b> 773.5 DUE TO (b) <b>Probable hyaline membrane disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Prematurity</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>36 hr</b> <b>36 hr</b> <b>36 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>23 Feb</b> , 19 <b>62</b> , to <b>24 Feb</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>23 Feb</b> , 19 <b>62</b> , and that death occurred at <b>7:45 A</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>James I. Hudson</b> M.D. <b>22c. PHYSICIAN'S NAME (Type)</b> <b>James I. Hudson, M.D.</b>		<b>22b. DATE SIGNED</b> <b>24 Feb 62</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>22d. ADDRESS</b> <b>Edgewater, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>3-3-1962</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Brewer Hill</b>	<b>23d. LOCATION (City, town or county)</b> (State) <b>Annapolis Md</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>William Keese</b> ADDRESS <b>Annapolis Md</b>		<b>25a. REC'D BY REGISTRAR</b> <b>WAR</b> <b>9 '62</b>	<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hines</b>

2-002977

05701

01278

Anne Arundel

Annapolis

Anne Arundel County

Male Negro

William H. Love

James I. Hudson, M.D.

Loganville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH Item 8 film G307jac 01461											
01477											
1. PLACE OF DEATH e. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN IN- stitution 27 days and 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Melrose Str.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital						d. STREET ADDRESS Melrose Str.					
3. NAME OF DECEASED (Type or print) Carlton P. Lumpkins (Lumkins)						4. DATE OF DEATH Month 2 Day 11 Year 19 62					
5. SEX M		6. COLOR OR RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/12/1894/ 1895		9. AGE (In years last birthday) 65 66 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (County & State, or foreign country) Howard Co., Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lumkins						14. MOTHER'S MAIDEN NAME Annie Dorsey Johnson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. World War I. 217050311		17. INFORMANT Hospital Records Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adynamic ileus 5720 DUE TO Conditions, if any, which gave rise to immediate cause (b) Early peritonitis (c) Regional ileitis (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from 12/15, 1961, to 2/11, 1962, that (I) (we) last saw the deceased alive on 2/11, 1962, and that death occurred 12:30 pm on the causes and on the date stated above.											
22a. SIGNATURE Carl B. Schleifer M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 12 FEB 62		
22c. PHYSICIAN'S NAME (Type) CARL B. SCHLEIFER M.D.						22d. ADDRESS 363 DEWEY DR ANNAPOLIS MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2/16/62		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. B.M.		23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE March 28 E. North A						25a. REC'D BY REGISTRAR DATE FEB 13 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

1940

1940

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01478

CERTIFICATE OF DEATH

01462

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b> c. LENGTH OF STAY IN b <b>2 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Elvaton Road (Elvaton)</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville, (Elvaton)</b> d. STREET ADDRESS <b>Elvaton Road - Box #182</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FLORENCE</b> First <b>MACHIA</b> Middle <b>February 13th, 1962</b> Last Date of Death		4. DATE OF DEATH Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>14th Dec. 1900</b>
9. AGE (In years last birthday) <b>61</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Elmore, Vermont</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Wheeler</b>		14. MOTHER'S MAIDEN NAME <b>Clara Emerson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mr. Orrin N. Machia</b>		Address <b>Same As #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Chronic Passive Congestion of Heart</b> (c) <b>Hypertension, ASCVD</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>months</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>49. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/29</b> , 1962 to <b>2/13</b> , 1962, that (I) <del>(we)</del> last saw the deceased alive on <b>2/10</b> , 1962, and that death occurred at <b>2PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Ernest A. Leopold</b> M.D.		22b. DATE SIGNED <b>2/13/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ernest A. Leopold</b>		22d. ADDRESS <b>425 S. Ritchie Hwy, Glen Burnie, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>17th Feb. '62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Northfield, Vermont</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Richard V. Singleton</b> ADDRESS <b>Glen Burnie, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 15 '62</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

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Allen Burns, No.

11/11/1944

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01479  
CERTIFICATE OF DEATH  
02708

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>1 mo. 5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1806 E. Fayette Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Lawrence</b>		4. DATE OF DEATH Month <b>2</b> Day <b>16</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1905</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>56</b> Days <b>16</b> Hours <b>1962</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>491X</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Dementia due to Encephalitis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour e.m.----- p.m.----- <b>19</b>		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State) <b>1/11</b> <b>1962</b> to <b>2/16</b> <b>1962</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> <b>1962</b> , to <b>2/16</b> <b>1962</b> , that (I) (we) last saw the deceased alive on <b>2/16</b> <b>1962</b> , and that death occurred at <b>7:15 P</b> <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Hildegard Heard Reissman</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissman, M.</b>		22b. DATE SIGNED <b>2/16/62</b> 22d. ADDRESS <b>D. Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b> 23b. DATE THEREOF <b>3-7-62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>B. G. Md.</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, D - Anns. Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 8 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Clotney S. Hanna</b>	

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Handwritten notes and signatures at the bottom of the page, including a signature that appears to read "J. B. ...".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01480 CERTIFICATE OF DEATH 01463

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>* Colonial Ave. Keeney's Apt's</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b> d. STREET ADDRESS <b>1 Colonial Ave. Keeney's Apts.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LILLIAN</b> First <b>McDONALD</b> Middle <b>MORRISON</b> Last 4. DATE OF DEATH <b>FEBRUARY 25,</b> 19 <b>62</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>March 5, 1897</b> 9. AGE (In years last birthday) <b>64 yrs.</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>own Home</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Winchester, Virginia</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Stephen Dandridge</b> 14. MOTHER'S MAIDEN NAME <b>Sidney Jane Kerns</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b> 16. SOCIAL SECURITY NO. <b>219-30-5338</b> 17. INFORMANT <b>Mr Charles W. Morrison- Husband - same as # 2</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic cancer of liver</b> DUE TO (b) <b>primary site?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Acvd</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5-3</b> , 19 <b>62</b> to <b>2-25</b> , 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>2-23-62</b> , and that death occurred at <b>1:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank Shipley</b> 22c. PHYSICIAN'S NAME (Type) <b>Frank Shipley MD</b>		22b. DATE SIGNED <b>2-26-62</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>Annapolis, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Feb. 28, 1962</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Martinsburg, West Virginia</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b> ADDRESS <b>Annapolis, Maryland</b> 25a. REC'D BY REGISTRAR <b>FEB 27 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thoma</b>	

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Colonel I. W. Brown, Jr.

x Colonel I. W. Brown, Jr.

February 19, 1902

February 19, 1902

Feb 2, 1902

Feb 2, 1902

Richmond, Virginia

Richmond, Virginia

Richmond, Virginia

Richmond, Virginia

210-30-333

*Handwritten notes:*  
The following is a list of the names of the persons who were present at the meeting held at the residence of the late Mr. J. W. Brown, Jr. on the 19th day of February, 1902.

Feb. 2, 1902

Feb. 2, 1902

## CERTIFICATE OF DEATH

Reg. Dist. No. **01465****01481**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kimbrough Army Hospital</b>		d. STREET ADDRESS <b>909 Park Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>MICHAEL</b> Middle <b>J</b> Last <b>POHLMAN</b>		4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>31 May 61</b>
9. AGE (In years lost birthday) yrs. <b>1</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>12</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Pohlman</b>		14. MOTHER'S MAIDEN NAME <b>Joyce Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>0</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Father</b>		Address <b>909 Park Ave Laurel, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration, severe</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Viral gastroenteritis</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>7 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1962</b> to <b>1962</b> , that I saw the deceased alive on <b>1962</b> , and that death occurred at <b>9:45 PM</b> from the causes and on the date stated above. <b>examined</b> ADDRESS (Street, city or town, state) <b>Kimbrrough AH Ft Geo G. Meade, Md.</b> DATE SIGNED <b>14 Feb 62</b>			
ACTUAL SIGNATURE <b>Morton Kane</b> M.D.			
PHYSICIAN'S NAME (Type) <b>MORTON C. KANE, Capt., M.C.</b> <b>Kimbrrough AH Ft Geo G. Meade, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/14/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery Dayton Ohio</b>	22d. LOCATION (City, town, or county) (State) <b>Dayton Ohio</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Donaldson</b>		24a. READ BY REGISTRAR DATE <b>FEB 19 '62</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and forward them to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01482

01466

1. PLACE OF DEATH a. COUNTY <i>Anne Arundale</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>1</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Brethensville</i>		c. LENGTH OF STAY in lb <i>1 yr 4 months</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Crownsville Hospital</i>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth Lizzie Price</i>		d. STREET ADDRESS <i>1633 LAFAYETTE AVE</i>	
5. SEX <i>FM</i>		6. COLOR OR RACE <i>C</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-6-93</i>	
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) <i>Va -</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Day</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>101-11-1111</i>	
17. INFORMANT <i>HOSPITAL RECORDS</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> DUE TO <i>Arteriosclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>420.0</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>One day.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>CBS approx. 2 years ago. Generalized arteriosclerosis &amp; Parkinson's Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10/1/60</i> 19... to <i>2/24/62</i> 19..., that (we) last saw the deceased alive on <i>2/22/62</i> 19..., and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above.		22a. SIGNATURE <i>L. Benedict M. D.</i>	
22b. DATE SIGNED <i>2/25/62</i>		22c. PHYSICIAN'S NAME (Type) <i>L. BENEDICT M. D.</i>	
22d. ADDRESS <i>CROWNDSVILLE STATE HOSPITAL</i>		22e. REC'D BY REGISTRAR <i>2/25/62</i>	
22f. REGISTRAR'S SIGNATURE <i>Charles E. Hume</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
23b. DATE THEREOF <i>Mar. 1, 1962</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wm. A. R. Cemetery</i>	
23d. LOCATION (City, town or county) (State) <i>Balto. Md.</i>		24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Waller</i>	
24a. ADDRESS <i>322 N. Schrock St</i>		24b. REC'D BY REGISTRAR <i>2/25/62</i>	
24c. REGISTRAR'S SIGNATURE <i>Charles E. Hume</i>		24d. DATE <i>FEB 28 '62</i>	

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*[Faint, mostly illegible handwritten text covering the majority of the page. The text appears to be a series of notes or a list, possibly related to a survey or inventory. Some words like "Station", "Area", and "Notes" are faintly visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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01483

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01467

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		d. STREET ADDRESS <u>117 Cathedral St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>117 Cathedral St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leslie</u> Middle <u>A.</u> Last <u>Guigley</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>11</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 98-1892</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Leslie Ward Carle</u>		14. MOTHER'S MAIDEN NAME <u>Katie Leavitt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>4. Craig Carle</u>		Address <u>Nyack N. Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Vaginal Sarcoma</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>2-11-1962</u> , that (I) (we) lost saw the deceased alive on <u>2-10-1962</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Shipley</u>		22b. DATE SIGNED <u>2-11-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK M. SHIPLEY</u>		22d. ADDRESS <u>Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 14-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cem</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 13 '62</u>	
ADDRESS <u>Annapolis Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01484 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01468

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severn</u> c. LENGTH OF STAY IN lb <u>Few instants</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>New Cut Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>14 Thomas Rd.</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pamela Gay Redmond</u>		4. DATE OF DEATH Month <u>February</u> Day <u>3rd</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/28/54</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Schoolgirl Elem. school</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Memorial Hosp. Riverdale, Md.</u>	11. BIRTHPLACE (State or foreign country) <u>USA</u>
13. FATHER'S NAME <u>Louis S. Redmond</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Louis Wampler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT <u>Mr. Louis S. Redmond (father)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Fracture of skull, Fracture of pelvis.</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Automobile in which she was riding slid and turned on the side.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile in which she was riding slid and turned on the side.</u>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>1.20 P.M. 2/3/62</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>New Cut Road</u> 20f. (City or town) <u>Severn</u> (County) <u>A.A.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2/3/62</u> Address (Street, city, town, or county) <u>Glen Burnie, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/6/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial Park</u>		22d. LOCATION (City, town, or county) <u>Dorsey Maryland</u>	
23. FUNERAL DIRECTOR <u>W. W. T. Canaldson, Laurel, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 8 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fournier</u>	

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United States

James of the ...  
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05375

1. PLACE OF DEATH

a. COUNTY

Anne Arundel County

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

116

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Anne Arundel

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

10 Annapolis

d. STREET ADDRESS

116 Conduit Street

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

First

Middle

Last

George

W.

Reid

4. DATE OF DEATH

Month

Day

Year

February 13

19 62

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Jan. 4, 1962

9. AGE (In years last birthday)

2 mos.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Allen Hoch Reid

14. MOTHER'S MAIDEN NAME

Nancy Kirwan Weltin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO. (If yes give number or dates of service)

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Pulmonary edema and intra-alveolar hemorrhages

773.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

19

20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county)

February 14, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify)

CREMATED

22b. DATE THEREOF

5-29-62

22c. NAME OF CEMETERY OR CREMATORY

City Morgue

22d. LOCATION (City, town, or county)

Balto. Md

(State)

23. FUNERAL DIRECTOR

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE MAY 31 '62

Arthur S. K...

00133

00133

Temporary copies and letters of introduction

County of Santa Clara City of San Jose

John W. ...

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 21201

01485

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN b. <b>12 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2446 Cherry Hill Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Eugene</b>				4. DATE OF DEATH Month <b>2</b> Day <b>21</b> Year <b>1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 4, 1913</b>	
9. AGE (In years last birthday) <b>48</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>			
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Henry Robinson</b>				14. MOTHER'S MAIDEN NAME <b>Bertha ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes 1942-1944</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paralytic ileus</b> <b>177X</b> DUE TO (b) <b>spinal cord tumor metastatic</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <b>ca of prostate</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>chronic brain syndrome associated E CNS syphilis 026X</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>-----</b> 19 p.m. <b>-----</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State) <b>-----</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/9</b> , 19 <b>62</b> to <b>2/21</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/21</b> , 19 <b>62</b> , and that death occurred at <b>12:10 a</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Lionel McHenry Mapp</b>				22b. DATE SIGNED <b>2/21/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>				22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/26/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>CHAS. RICE - 661 W. BARRE ST</b>				25a. REC'D BY REGISTRAR <b>2/22/62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

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CERTIFICATE OF DEATH

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DEATH OF

JOHN J. BROWN

JOHN J. BROWN

JOHN J. BROWN

JOHN J. BROWN

JOHN J. BROWN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE

## CERTIFICATE OF DEATH

01486

01470

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XSIDADYSIDE</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ARCHIE HARRISON ROGERS</u>		4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1962</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1908</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>11</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTENDANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Service Station</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Shady Side AACo Md</u>			
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>HARRISON H. ROGERS</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE M. HALLOCK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-05-2184</u>		17. INFORMANT <u>Mrs Anne M. Rogers Shady Side Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO <u>Hypertensive C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				INTERVAL BETWEEN ONSET AND DEATH <u>16 hours</u> <u>5-7 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/11/62</u> to <u>2/11/62</u> , that (I) (we) last saw the deceased alive on <u>2/11/62</u> , and that death occurred at <u>2/11/62</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>H. T. O'HERLICKY</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/11/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>H. T. O'HERLICKY</u>		22d. ADDRESS <u>5, Central Ave. Glen Burnie, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 14, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ovaler Cemetery</u>			
23d. LOCATION (City, town or county) <u>Galesville Md</u>		23e. (State) <u>Md</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>T A Hardesty + Son</u>		ADDRESS <u>Galesville, Md</u>		25a. REC'D BY REGISTRAR <u>Anthony S. Kline</u>			
25b. REGISTRAR'S SIGNATURE		DATE <u>FEB 14 '62</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01487

01471

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A.A.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hanover, Md</b>		c. LENGTH OF STAY IN 1b <b>X Hanover, Maryland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Box 114-D Dorsey Road</b>		d. STREET ADDRESS <b>Box 114-D Dorsey Road</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>P.</b> Last <b>Sanderson</b>		4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1962</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1878</b>
9. AGE (In years last birthday) yrs. <b>84</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Eden Flowers</b>		14. MOTHER'S MAIDEN NAME <b>Margaret (unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YE NO</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Travis A. Gibbs, Dorsey Road, Hanover, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute dehydration</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>carcinoma of the stomach</b> DUE TO (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2-16</b> , 19 <b>62</b> to <b>2-18</b> , 19 <b>62</b> ; that (I) (we) last saw the deceased alive on <b>2-18</b> , 19 <b>62</b> ; and that death occurred at <b>5:30</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>E. Roderick Shipley</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>E. Roderick Shipley</b>		22d. ADDRESS <b>529 Camp Meade Road.</b>	
23a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2-21-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Baltimore</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 21 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01488

Item 2 Film G308

5/5/62 iwl

01472

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>-</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Burnie</b>		c. LENGTH OF STAY IN 1b <b>17 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 23, Md.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>6 North Calhoun St.</b> <b>Baltimore City Hospitals</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Saro</b> Last <b>-</b>		4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-14-1883</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Unknown Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unknown USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-01-4403</b>	
17. INFORMANT <b>Mr. Marani, Balto. D.P.W.</b>		Address <b>-</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma breast and colon</b> <b>199X</b> DUE TO <b>(Surgery in University Md. Hospital Sept. 1961)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>-</b> DUE TO <b>-</b> (c) <b>-</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardio renal vascular disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>-</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>-</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State) <b>-</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 9, 1960</b> to <b>Feb. 19, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 17, 1962</b> , and that death occurred at <b>5P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>James M. Pair</b>		22b. DATE SIGNED <b>2-20-1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>		22d. ADDRESS <b>400 N. Carrollton Avenue Balto. 23 Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-23-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore County</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. cook, Inc., 1217 St. Paul Street, ZONE 2</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 26 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

01475

CERTIFICATE OF DEATH

01475

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01489

01473 -

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>und</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Betty Bunnell Sassaman</u>		4. DATE OF DEATH <u>2-26-62</u> 19 <u>62</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3<sup>rd</sup> Nov. 1910</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>26</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Leitham Bunnell</u>		14. MOTHER'S MAIDEN NAME <u>Bertrude Steuker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>25407-1831</u>	
17. INFORMANT <u>Kenneth Sassaman</u> Address <u>503 Kent Circle, Glen Burnie, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis C.V. Disease</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 1962</u> and that death occurred at <u>8A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Hahn, M.D.</u>		22d. ADDRESS <u>Severna Park Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>28 Feb '62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u>		23d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. F. Singleton</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 28 '62</u>	
ADDRESS <u>Glen Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>William L. Hahn</u>	

STATE OF NEW YORK

1889

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01490 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01474

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Jessups</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>14 mos.</b>				d. STREET ADDRESS <b>640 W. Franklin St.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Maryland House of Correction</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES H. SAWYER</b>				4. DATE OF DEATH Month Day Year <b>February 19 19 62</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/28/23</b>	
9. AGE (In years last birthday) <b>38 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Elizabeth City NC</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>John</b>				14. MOTHER'S MAIDEN NAME <b>Mary Banks</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>237-03-1109</b>		17. INFORMANT Address <b>Maryland House of Correction Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> <b>443X</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Partial</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Partial</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Rudiger Breiteneker</b> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) <b>Rudiger Breiteneker, M.D.</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>Feb. 20, 1962</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-26-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR ADDRESS <b>Adolphus Halstead 918 Druid Hill Ave.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 27 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

0851C

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01491

CERTIFICATE OF DEATH

Reg. No. 01175

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Glen Burnie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>607 Baylor Rd.</b>		d. STREET ADDRESS <b>607 Baylor Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>ESTELLE M. SCHAEFER</b>		4. DATE OF DEATH <b>Feb 28 1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12/9/1905</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick Litz</b>		14. MOTHER'S MAIDEN NAME <b>HENRIETTA LINK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>James Schaefer SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis general</b> <b>153.8</b> DUE TO <b>Carcinoma of colon</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 Yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec 1959</b> to <b>Feb 28 1962</b> , that I last saw the deceased alive on <b>Feb 20 1962</b> , and that death occurred at <b>10<sup>00</sup> A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph Taler</b>		DATE SIGNED <b>2-28-62</b>	
PHYSICIAN'S NAME (Type) <b>JOSEPH TALER</b>		ADDRESS (Street, city or town, state) <b>102 BdA Blvd. N.E. GLENBURNIE, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>3/5/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>LONDON PARK Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTIMORE Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. G. Ruck Inc</b>		ADDRESS <b>5305 HARFORD RD.</b>	
24a. REC'D BY REGISTRAR <b>MAR 2 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. Thomas</b>	

01331

CERTIFICATE OF DEATH

1915

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CC</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brocklyn PK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>929 Hammonds Lane</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brocklyn PK</u> d. STREET ADDRESS <u>929 Hammonds Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nora Ann Schmidt</u>		4. DATE OF DEATH Month Day Year <u>2-17-1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-83</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. FATHER'S NAME <u>Lulin Stewart</u>		13. MOTHER'S MAIDEN NAME <u>IDA Huber</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>NO</u>		15. SOCIAL SECURITY NO. <u>Family</u>	
16. INFORMANT <u>Family</u>		17. Address <u>Some</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> 422.2 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>generalized arteriosclerosis C.V. disease</u> (c) <u>underlying</u> cause test. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Terminal bronchopneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 2/15</u> , 19 <u>62</u> to <u>2/17</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>2/15</u> , 19 <u>62</u> , and that death occurred at <u>8:00</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Sidney R. Gehlert</u> M.D.		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Sidney R. Gehlert, M.D.</u>		22d. ADDRESS <u>4700 Pennington Ave. Balto. #26, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE THEREOF <u>2-20-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cider Haven Cem</u>	23d. LOCATION (City, town or county) (State) <u>Cider Haven Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>McCurdy Funeral Home</u>		25. REC'D BY REGISTRAR DATE <u>FEB 20 '62</u>	
ADDRESS <u>1306 Fort Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01493

01477

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>59 Calvert Street</b>		d. STREET ADDRESS <b>59 Calvert Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>ALBERT</b> Last <b>SCISCO</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>4</b> Year <b>19 62</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6-1883</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gen. Utilities Retired Navy Acad.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Annapolis, Md.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Scisco</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Sands</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-16-0100</b>	
17. INFORMANT <b>Zora G. Scisco-59 Calvert St. Anna, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO <b>Hypertensive Sclerotic Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>?</b> DUE TO <b>?</b> (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 9, 1957</b> , to <b>Feb. 4, 1962</b> , that (I) (we) last saw the deceased alive on <b>Feb. 4, 1962</b> , and that death occurred at <b>11 am</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thodore H. Johnson M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>2/6/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>T.H. Johnson</b>		22b. DATE SIGNED <b>2/6/62</b>	
22d. ADDRESS <b>Dean Street Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 8-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hicks III</b>		ADDRESS <b>Annapolis, Md.</b>	
25a. REC'D BY REGISTRAR <b>FEB 13 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>	

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**Abstract**

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**52. Hogen:**

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Figure 1

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THE DIAL, 3.3

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01494

01478

Item 7 Film G307 2/26/62 iwk

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>16 years</b> <b>10 mos. 17 days</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <b>Maryland</b>		b. COUNTY <b>Calvert</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dares Wharf</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Carrie</b>		First <b>Carrie</b>		Middle <b>Scott</b>		Last <b>Scott</b>		4. DATE OF DEATH Month <b>2</b>		Day <b>13</b>		Year <b>1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> <b>Single</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		8. DATE OF BIRTH <b>October 23, 1923</b>		9. AGE (In years last birthday) <b>38</b> yrs.		IF UNDER 1 YEAR Months <b>2</b>		IF UNDER 24 HRS. Days <b>13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Leroy Scott</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Parran</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>								Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X</b> <b>Diabetes Mellitus</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>											
20c. TIME OF INJURY Hour a.m. p.m. <b>----- 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b>		(County) <b>-----</b>		(State) <b>-----</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>3/26</b> 19 <b>62</b> , to <b>2/13</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> 19 <b>62</b> , and that death occurred at <b>8:38 A.</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>L. Benedict</b>		M.D. <b>L. Benedict, M. D.</b>		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/13/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2-17-62</b>		23b. DATE THEREOF <b>2-17-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Plum Point</b>		23d. LOCATION (City, town or county) <b>Calvert</b>		(State) <b>md</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Pinkney &amp; Sewell</b>				ADDRESS <b>Prince Frederick</b>		25a. REC'D BY REGISTRAR <b>FEB 20 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Wm. S. Hines</b>					

07410

10110

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician, and completely filled in by the funeral director. Page 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01495

## CERTIFICATE OF DEATH

01479

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY in lb <b>8 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>E.</b> Last <b>SEITZINGER</b>		4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1895</b>
9. AGE (In years last birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>1</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHARMACIST Ret. PHARMACIST</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>William M. Seitzinger</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Jane Morse</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>	
16. SOCIAL SECURITY NO. <b>W.W.I</b>		17. INFORMANT <b>D. Evelyn Gingell</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure due to metastatic carcinoma</b> 1577X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of the pancreas</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>4 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Richard I. Hochman</b> attended the deceased from <b>Nov. 6, 1961</b> to <b>Feb. 1, 1962</b> that (I) <b>yes</b> last saw the deceased alive on <b>Feb. 1, 1962</b> , and that death occurred at <b>11:10 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard I. Hochman</b> M.D.		22b. DATE SIGNED <b>2/2/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard I. HOCHMAN</b>		22d. ADDRESS <b>59 Franklin St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 5-1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Annapolis National</b>		23d. LOCATION (City, town or county) (State) <b>Annapolis Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sons</b>		25a. REC'D BY REGISTRAR <b>Feb 5 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>			

01110

01110

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01496

01480

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>H.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOMEWOOD Nursing Home</u>		d. STREET ADDRESS <u>111 MARKET ST</u>	
3. NAME OF DECEASED (Type or print) First <u>BERTHA</u> Middle <u>W.</u> Last <u>SHANNON</u>		4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-1880</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet-metal Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL WOOD</u>		14. MOTHER'S MAIDEN NAME <u>MARY F. COOPER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT Address <u>MARGARET T. BAKER #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 4-20-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>no</u> DUE TO (c) <u>no</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL THROMBOSIS (OLD)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 1960</u> to <u>2-15-1962</u> that (I) (we) last saw the deceased alive on <u>2-14-1962</u> and that death occurred at <u>12 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u> M.D.		22b. DATE SIGNED <u>3/16/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>73 FRANKLIN ST ANNAPOLIS MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-17-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		23d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>		24b. ADDRESS <u>Annapolis, Md.</u>	
25a. REC'D BY REGISTRAR <u>DATE FEB 20 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Henson</u>	

0180

CERTIFICATE OF DEATH

0180



10

DECEASED  
MARGARET J. BAKER

1900



FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01497

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01481

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Same</b> b. COUNTY <b>Same</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				c. LENGTH OF STAY IN 1b <b>28y.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1506 Gov. Ritchie Highway</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Thomas P. Shipley</b>				4. DATE OF DEATH Month <b>February</b> Day <b>5th.</b> Year <b>19 62</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/15/09</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months <b>52</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk at the Md. Dry Dock</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Glen Burnie, Md.</b>			
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Carl H. Shipley</b>				14. MOTHER'S MAIDEN NAME <b>Rose Pumphrey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-18-8736</b>		17. INFORMANT <b>Mrs. Clara Shipley (wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>420.1</b> (c) <b>420.1</b> DUE TO (e), stating the underlying cause test. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>2/6/62</b>			
				Address (Street, city, town, or county) <b>Glen Burnie, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8th Feb. '62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial Park</b>		22d. LOCATION (City, town, or country) (State) <b>Glen Burnie, Maryland</b>	
23. FUNERAL DIRECTOR <b>R. V. Singleton</b>				ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR <b>Feb 13 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

01181

01181



James H. [illegible]

101

101

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01498

## CERTIFICATE OF DEATH

01482

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Anne Arundel Gen. Hosp.</b>				d. STREET ADDRESS <b>202 W. Hilltop Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rufus O. Simmons</b>				4. DATE OF DEATH <b>February 24, 1962</b>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 24, 1878</b>	
9. AGE (In years last birthday) <b>83</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>William Simmons</b>				14. MOTHER'S MAIDEN NAME <b>Emma Ruark</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-2903</b>		17. INFORMANT <b>Mrs. Hattie Simmons</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio - Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Arterio - Sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> , to <b>1962</b> , that (I) (we) last saw the deceased alive on <b>1962</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. 22a. SIGNATURE <b>Chas. L. Ball Jr.</b> 22b. DATE SIGNED <b>Feb. 26, 1962</b> 22c. PHYSICIAN'S NAME (Type) <b>Charles L. Ball Jr.</b> 22d. ADDRESS <b>203 W Maple Road Linthicum, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 27, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem. Pk.</b>		23d. LOCATION (City, town or county) (State) <b>Glen Burnie, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>George J. Gonce</b> <b>George J. Gonce</b>				ADDRESS <b>4001 Ritchie Hwy. (25)</b>		25a. REC'D BY REGISTRAR <b>MAR 1 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

01493

01493



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01499						01483					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		
Anne Arundel			Severna Park			Maryland			Anne Arundel		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			48 Baltimore & Annapolis Blvd.			d. STREET ADDRESS			Rt. #2 Box 593A		
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
WILLIAM CHARLES STINCHCOMB						February 4			19 62		
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White				29th Sept. '61		4		Months Days	
										Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
none				none				Annapolis, Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
William Charles Stinchcomb, Sr.				Ethel Mae Marsteller				U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address			
no				none				Mr. William C. Stinchcomb Same As #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a)											
754.5 DUE TO Cerebral Hemorrhage											
(b)											
DUE TO Congenital Heart Disease											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Sept. 30, 1961 to Feb. 7, 1962, that (I) (we) last saw the deceased alive on Feb. 7, 1962, and that death occurred at 11:40 AM from the causes and on the date stated above.											
22a. MONITOR											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) Clayton Norton											
22d. ADDRESS Severna Park, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City, town or county) (State)											
Burial Feb. 6th, 1962 Cedar Hill Cemetery Brooklyn, RFD, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											
Richard T. Singleton Glen Burnie, Md. DATE FEB 8 '62 Arthur S. Haines											

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01183

01183

Central West Division  
Central West Division

Chapman / Carter

Sept 30  
1944

General  
S. B. Burnie  
S. B. Burnie  
S. B. Burnie

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. 011484

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>63 Conduit St.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
f. STREET ADDRESS <i>63 Conduit</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Jewell</i> Middle <i>S</i> Last <i>Sullivan</i>		4. DATE OF DEATH Month <i>2</i> Day <i>22</i> Year <i>1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 10 1893</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James T. Small</i>		14. MOTHER'S MAIDEN NAME <i>Ella Jewell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>63-123456789</i>	
17. INFORMANT <i>Ella S. Colbert</i>		Address <i>2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac</i> 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i> sudden</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>2-22-62</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-24-1962</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cent</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR <i>DATE FEB 27 '62</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01421

01421

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY		19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
21. SIGNATURE OF JURY		22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY		25. SIGNATURE OF JURY	
26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY	
36. SIGNATURE OF JURY		37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY		49. SIGNATURE OF JURY		50. SIGNATURE OF JURY	
51. SIGNATURE OF JURY		52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY	
56. SIGNATURE OF JURY		57. SIGNATURE OF JURY		58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY		64. SIGNATURE OF JURY		65. SIGNATURE OF JURY	
66. SIGNATURE OF JURY		67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY		70. SIGNATURE OF JURY	
71. SIGNATURE OF JURY		72. SIGNATURE OF JURY		73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
81. SIGNATURE OF JURY		82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY		85. SIGNATURE OF JURY	
86. SIGNATURE OF JURY		87. SIGNATURE OF JURY		88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY		94. SIGNATURE OF JURY		95. SIGNATURE OF JURY	
96. SIGNATURE OF JURY		97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY		100. SIGNATURE OF JURY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01501

CERTIFICATE OF DEATH

01485

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>61 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>		d. STREET ADDRESS <u>140 Market St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. El. General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mills Kirby Summer</u>		4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-13-1900</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carell Hall Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mills Summer</u>		14. MOTHER'S MAIDEN NAME <u>Lucretia A. Appleby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>	
17. INFORMANT <u>Lucretia Snowden</u>		Address <u>140 Market St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-15-62</u> to <u>2-15-62</u> , that (I) (we) last saw the deceased alive on <u>2-15-62</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William T. Allen</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM T. ALLEN</u>		22d. ADDRESS <u>61 Crabtree St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 2-17-1962</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		23d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 16 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

01501

CERTIFICATE OF DEATH

0188

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

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01502

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01486

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1 year 7 mos. 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 895 Boyd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Abrahn (Alias: Abraham)		First Middle Last Taylor		4. DATE OF DEATH 2 12 1962		Month Day Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1886		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Taylor		14. MOTHER'S MAIDEN NAME Marlia					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-7000		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cardiovascular and Renal Disease (e), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a.m.----- p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/3 1958 to 2/12 1962, that (I) (we) last saw the deceased alive on 2/12 1962, and that death occurred at 1:45 PM from the causes and on the date stated above.							
22a. SIGNATURE L. Benedict, M. D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 2/13/62	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 17, 1962		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. Baltor. Md.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Katie R. Willie				25a. REC'D BY REGISTRAR DATE FEB 19 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

01198

01208



RECEIVED 00, 1900

RECEIVED 00, 1900

*[Faint, illegible handwritten text at the bottom of the page]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01503

01487

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>1 day 1 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> d. STREET ADDRESS <b>733 Richmond Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Maria Taylor</b>		<b>4. DATE OF DEATH</b> Month <b>2</b> Day <b>27</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>July 23, 1891</b>
<b>9. AGE</b> (In years last birthday) <b>70</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Unknown</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>John Williams</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>219-05-8417</b>		<b>17. INFORMANT</b> <b>Hospital Records</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Coronary Occlusion</b> DUE TO (c) <b>Coronary Arteriosclerosis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) -----	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m.----- p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) -----		<b>20f. (City or town)</b> (County) (State) -----	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1/26</b> , <b>1962</b> , to <b>2/27</b> , <b>1962</b> , that (I) (we) last saw the deceased alive on <b>2/27</b> , <b>1962</b> , and that death occurred at <b>8:52 a.m.</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>L. Benedict, M. D.</b>		<b>22b. DATE SIGNED</b> <b>2/27/62</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>L. Benedict, M. D.</b>		<b>22d. ADDRESS</b> <b>Crownsville State Hospital, Maryland</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>23b. DATE THEREOF</b> <b>3/4/62</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Green Acres</b>	<b>23d. LOCATION</b> (City, town or county) (State) <b>Wicomico Salisbury Md</b>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Clinton H. Stewart By</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Thomas</b>	
<b>DATE</b> <b>2/23/62</b>		<b>DATE</b> <b>2/23/62</b>	

01227

01203

M

Handwritten notes and stamps, including "01227", "01203", and "M". The text is mostly illegible due to blurring and bleed-through from the reverse side of the page. Some visible fragments include "Handwritten", "01227", "01203", "M", "Handwritten", "01227", "01203", "M", "Handwritten", "01227", "01203", "M".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
01504 01488									
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>2 mos. 14 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b> d. STREET ADDRESS <b>Unknown</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gladys Pearl Thomas</b>					4. DATE OF DEATH Month Day Year <b>2 28 1962</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 8, 1916</b>		9. AGE (In years last birthday) <b>45</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland - Rock Hall</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Thomas</b>					14. MOTHER'S MAIDEN NAME <b>Martha Brown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Hospital Records</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertensive Cardiovascular Disease</b> (c) <b>Right Hemiplegia</b> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>----- 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b>		20g. (County) <b>-----</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>12/14 1961</b> to <b>2/28 1962</b> , that (I) (we) last saw the deceased alive on <b>2/28 1962</b> , and that death occurred at <b>8:05 P.M.</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>Lionel McHenry Mapp, M. D.</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/1/62</b>		
22c. PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>					22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Mar 5/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sharptown Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rock Hall, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin L. Wellman - Chestertown, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>MAR 6 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>		

01110

12908

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01505						01489					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			e. STATE			b. COUNTY		
13. NAME OF DECEASED (Type or print)			14. DATE OF DEATH			15. AGE (In years last birthday)			16. IF UNDER 1 YEAR		
17. SEX			18. COLOR OR RACE			19. MARIED			20. NEVER MARRIED		
21. MALE			22. FEMALE			23. WIDOWED			24. DIVORCED		
25. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			26. 10b. KIND OF BUSINESS OR INDUSTRY			27. 11. BIRTHPLACE (County, State, or foreign country)			28. 12. CITIZEN OF WHAT COUNTRY?		
29. 13. FATHER'S NAME			30. 14. MOTHER'S MAIDEN NAME			31. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			32. 16. SOCIAL SECURITY NO.		
33. 17. INFORMANT			34. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			35. 19. WAS AUTOPSY PERFORMED?			36. 20. INTERVAL BETWEEN ONSET AND DEATH		
37. PART I. DEATH WAS CAUSED BY:			38. IMMEDIATE CAUSE (a)			39. DUE TO			40. DUE TO		
41. CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.			42. (b)			43. (c)			44. (d)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY						20d. INJURY OCCURRED					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town)					
20g. (County)						20h. (State)					
21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1962 to Feb. 3, 1962, that (I) (we) last saw the deceased alive on Feb. 2, 1962, and that death occurred at 7 A.M. from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE THEREOF					
23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City, town or county)					
23e. FUNERAL DIRECTOR'S SIGNATURE						23f. ADDRESS					
25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
Anne Arundel, MARYLAND						Md. A. A.					
Churchton						Churchton					
Keith Lamarr Thompson						Feb. 3 1962					
Male						Negro					
Nov. 26-1961						2					
Maryland						U.S.A.					
John Thompson						Loretta B. Offer					
Loretta B. Thompson Churchton Md.						3 days					
Dehydration						Infantile diarrhea (viral diarrhea)					
571.0						2 weeks					
Feb. 1, 1962 to Feb. 3, 1962											
Willard F. Smith, MD						2/3/62					
Burial 2-5-1962						St. Matthews					
Shady Side Md.						Shady Side Md.					
William Reese H. Anna. M.D.						Feb 9 '62					
Arthur S. Kraus											

2063309023

(M)

015054

CERTIFICATE OF DEATH

015054

*[Faint, illegible text, likely bleed-through from the reverse side of the document. The text appears to be a certificate of death, mentioning names and dates.]*

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01506

CERTIFICATE OF DEATH

01490

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Selby Edgewater</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Selby Edgewater</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Riva Manor Guest House- RIVA NURSING HOME</u>		d. STREET ADDRESS <u>(on the Bay)</u>	
3. NAME OF DECEASED (Type or print) <u>Ediza Fitzpatrick Tighe</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>17</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-9th 1859</u>
9. AGE (In years lost birthday) <u>102</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Fitzpatrick</u>		14. MOTHER'S MAIDEN NAME <u>Mary Marrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Robert S. Thorne</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lobar Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-11-1962</u> to <u>2-17-1962</u> and that death occurred <u>12</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>Catharine St Annapolis Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-21-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>HOLY SEPULCHER</u>		23d. LOCATION (City, town, or county) (State) <u>EAST ORANGE N. J.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 21 '62</u>	
ADDRESS <u>Sous Annapolis, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thorne</u>	

01502

REVENUE OF DEPT.

01492

(M)

W. W.

100

REVENUE OF DEPT.

REVENUE OF DEPT.

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## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01507

01491

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>1 mo. 7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1753 Mullekin Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Uzzle</b>		4. DATE OF DEATH Month Day Year <b>2 12 19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 1, 1901</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>12 19</b>	11. IF UNDER 24 HRS. Hours Min. <b>62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Uzzle</b>		14. MOTHER'S MAIDEN NAME <b>Susan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>304X</b> DUE TO <b>Dehydration and Inanition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State) <b>-----</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1/5/1962</b> to <b>2/12/1962</b> , that (I) (we) last saw the deceased alive on <b>2/12/1962</b> , and that death occurred at <b>9:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. Benedict, M. D.</b>		22b. DATE SIGNED <b>2/13/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		22d. ADDRESS <b>Crownsville State Hospital, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/17/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. Auburn Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Wheaton Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>P.O. Wilson</b>		25a. REC'D BY REGISTRAR <b>1000 Broadway Ave.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hance</b>		DATE <b>FEB 14 '62</b>	

(M)

1950

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01508

## CERTIFICATE OF DEATH

Reg. Dist. No. 01492

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>320 Locust Ave.</b>				d. STREET ADDRESS <b>320 Locust Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>DELORES ACHENBACK VANYO</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>24</b> Year <b>19 62</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 10, 1906</b>		9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>_____</b>				14. MOTHER'S MAIDEN NAME <b>_____</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Stephen R. Vanyo - Husband - same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Dehydration</b> <b>260X</b> DUE TO <b>(Dehydration Mellitus)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>(Generalized carcinoma metastases)</b> DUE TO <b>Carcinoma of the Pancreas</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Several days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11</b> , 19 <b>61</b> , to <b>2124</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>7/24</b> , 19 <b>62</b> , and that death occurred at <b>12:30</b> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Albert L. Anderson</b>				M.D. <b>44 Southgate Ave. Annapolis, Md. 7/24/62</b>			
PHYSICIAN'S NAME (Type) <b>Albert L. Anderson MD</b>				ADDRESS (Street, city or town, state) <b>Southgate Ave, Annapolis, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 26, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 27 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

# CERTIFICATE OF DEATH

31208

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
01509  
01493  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>A.A.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>113 Ferndale Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A.A.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b> d. STREET ADDRESS <b>3 Ferndale Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <b>Elizabeth R Voorhese</b>		4. DATE OF DEATH Month Day Year <b>February 13 19 62</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1892</b>	9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days <b>69</b>	IF UNDER 24 HRS. Hours Min. <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Samuel K. Galloway</b>		14. MOTHER'S MAIDEN NAME <b>Alice Cliburn</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Wm.C.Voorhese, 113 Ferndale Road, Glen Burnie, Md</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circ. Myocardial Failure</b> <b>157</b> DUE TO <b>Ca of Pancreas &amp; metastases</b> Conditions, if any, which gave rise to immediate cause (b) <b>arterio-sclerotic C.V.R. &amp;</b> (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>1 day 1 hr 29 min</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>11/9</b> to <b>2/13</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> , 19 <b>62</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above.						
22a. SIGNATURE <b>Joseph G. Laukaitis M.D.</b>		22b. DATE SIGNED <b>2/14/62</b>		22c. ADDRESS <b>679 Washington Blvd., Baltimore 30</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-15-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc., 1217 St. Paul Street, Baltimore 2</b>			25. REC'D BY REGISTRAR DATE <b>FEB 16 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

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*Handwritten notes:*  
The following is a list of the names of the persons who were present at the meeting held on May 23, 1943, at the home of Mrs. J. H. [illegible] in the city of [illegible].

*Handwritten signature:* J. H. [illegible]

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01510

01494

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Green Haven</u> c. LENGTH OF STAY in b <u>20 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3rd Street</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Green Haven</u> d. STREET ADDRESS <u>3rd. Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Catherine Warfield</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>February 19, 1962</u> Month Day Year					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 14, 1883</u>			
<b>9. AGE</b> (In years last birthday) <u>78</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S.</u>				<b>13. FATHER'S NAME</b> <u>John Cook</u>					
<b>14. MOTHER'S MAIDEN NAME</b> <u>Catherine</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					
<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>Mr. Allen T. Warfield</u> Address <u>Same</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cordis Venular Stenosis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>422.1</u> (c) <u>422.1</u> DUE TO (e), stating the underlying cause last.								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>7 yrs.</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan., 1955</u> to <u>Feb. 19, 1962</u> that (I) (we) last saw the deceased alive on <u>Feb. 19, 1962</u> and that death occurred at <u>10:25 AM</u> , from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <u>G. Brady Smith</u> M.D.				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Feb. 20, 1962</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Brady Smith M.D.</u>				<b>22d. ADDRESS</b> <u>Riviera Beach, A. A. Co., Md.</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Feb. 22, 1962</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Holy Redeemer Cem.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>George J. Gonce</u> ADDRESS <u>4001 Ritchie Hwy. (25)</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Feb 27 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Frame</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01511

01495

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Benfield Rd -- Millersville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kushwood Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Rosin Watson</u>		4. DATE OF DEATH Month Day Year <u>2-13-62</u> 19 <u>62</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 16, 1881</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Stillpond Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wm. S. Rosin</u>		14. MOTHER'S MAIDEN NAME <u>Angie Warren</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>H. James Watson</u>		Address <u>Benfield Rd, Millersville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Cerebral Hemorrhage</u> 443 DUE TO (b) <u>Hypertensive C.V. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Gen. arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>62</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> to <u>1962</u> , that (I) (we) last saw the deceased alive on <u>2-8-1962</u> and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u>		22b. DATE SIGNED <u>2-13-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>		22d. ADDRESS <u>Severna Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-15-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>STILL POND CEMT</u>		23d. LOCATION (City, town, or county) (State) <u>STILL POND, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 16 '62</u>	
ADDRESS <u>STILL POND, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hahn</u>	

01432

CERTIFICATE OF DEATH

01511

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CHIEF CLERK

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND  
CERTIFICATE OF DEATH

01512		01498	
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN lb <u>40 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore.</u> d. STREET ADDRESS <u>607 Pennsylvania Ave.</u> 3V01-4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>D</u> Last <u>WILLIAMS</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/1910</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown.</u>		14. MOTHER'S MAIDEN NAME <u>Georgia ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-05-7921</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hypertensive Cardiovascular Renal Disease.</u> (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) <u>Syphilis and Chronic Brain Syndrome due to Cerebral Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/3/62</u> to <u>2/12/62</u> , that (I) (we) last saw the deceased alive on <u>1/3/62</u> , and that death occurred at <u>11/3/62</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Lionel M. Henry Mapp</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Lionel M. Henry Mapp</u>		22b. ADDRESS <u>Crownsville State Hospital, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/15/62</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Ambrose</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frances Hardy</u>		25. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>	
25. DATE <u>FEB 16 '62</u>		25b. REGISTRAR'S SIGNATURE	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Your files should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01513

01497

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel Co.</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 25</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore 25</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>603 Regatta Avenue, Terrace View</b>				d. STREET ADDRESS <b>603 Regatta Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>KURT P. WISE</b>				4. DATE OF DEATH <b>February 21, 1962</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/20/92</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Draftsman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		9. AGE (in years last birthday) <b>69</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
13. FATHER'S NAME <b>William Wise</b>				14. MOTHER'S MAIDEN NAME <b>Simon</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. H. P. Packert, 2308 Poplar Dr., Balto. 7</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Howard G. Shaub</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>HOWARD G. SHAUB, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>				22b. DATE THEREOF <b>2/24/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
23. FUNERAL DIRECTOR <b>Ellsworth Armacost</b>				22d. LOCATION (City, town, or country) <b>Baltimore, Maryland</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ADDRESS <b>4600 Liberty Heights Ave.</b>				24a. REC'D BY REGISTRAR <b>FEB 27 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

2/22/62

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*[Handwritten signature]*

WILLIAM H. HARRIS

1000 Liberty Street, New York, N.Y.

1000 Liberty Street, New York, N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

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01514

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>2yrs.10 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Plaza Manor Nursing Home</b>		d. STREET ADDRESS <b>Rt.2 Holly Beach Farm</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Wright</b> Last <b></b>		4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-11-1871</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Race horse caretaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Racing Stable</b>	
11. BIRTHPLACE (State or foreign country) <b>Bedford County, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Katie Wright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-18-7827A</b>	
17. INFORMANT <b>Mrs. H.A.Parr, 111 Rt.2 Holly Beach Farm, Annap.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meatastatic pulmonary carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of prostate</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.?</b> <b>3 yrs. ?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-6-1960</b> 19____, to <b>2-23-1962</b> 19____, that (I) (we) last saw the deceased alive on <b>2-17-1962</b> 19____, and that death occurred at <b>10PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James M. Pair</b>		22b. DATE SIGNED <b>2-12-1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>James M. Pair, M.D.</b>		22d. ADDRESS <b>400 N. Carrollton Ave. Balto.23,Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-27-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARYS</b>		23d. LOCATION (City, town, or county) (State) <b>ANNAPOLIS - MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hick III Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 2 '62</b>	
ADDRESS <b>Annapolis</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Pinner</b>	

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STATE OF TEXAS

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IN SENATE,  
January 11, 1911.  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE,  
FOR THE YEAR  
1910.  
BY  
J. M. HARRIS,  
COMMISSIONER.  
DALLAS: THE TEXAS BOOK CONCERN, 1911.

## CERTIFICATE OF DEATH

Reg. Dist. No. **01499****01515**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Millersville</b>		c. LENGTH OF STAY IN 1b <b>10</b> <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Knowltingwood Nursing Home</b>		d. STREET ADDRESS <b>1993 Fairfax Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>SYLVESTER CARL YOUNGREN</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>24</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29, 1886</b>
9. AGE (In years lost birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USN</b>	
11. BIRTHPLACE (State or foreign country) <b>Boston, Mass</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give year or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs Lottie G. Youngren- Wife- same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200 Cordone failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterio sclerotic heart disease</b> DUE TO (c) <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/19/62</b> , 19 <b>62</b> , to <b>2/24</b> , 19 <b>62</b> ; that I last saw the deceased alive on <b>2/19</b> , 19 <b>62</b> , and that death occurred at <b>11:01 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>G. Church</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. Gerard Church MD</b> <b>121 Cathedral Street, Annapolis, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>February 27, 62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 27 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

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Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1911		Home	
Cause of Death		Disease		Symptoms		Time of Death		Physician	
Heart Disease		Myocardial Infarction		Chest Pain, Shortness of Breath		10:30 AM		Dr. J. Smith	
Occupation		Education		Marital Status		Religion		Burial Place	
Teacher		High School		Married		Catholic		St. Mary's Church	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Official Seal		Official Title		Official Signature	
Jan 16, 1911		Baltimore, Md.		[Seal]		Registrar		[Signature]	